FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041699

Facility Name: Heritage Manor-Springfield

Address: 900 North Rutledge (Number) Springfield (City) 62702 (Zip Code)

County: Sangamon

Telephone Number: (217) 789-0930 **Fax #** ( )

HFS ID Number: 371359387001

Date of Initial License for Current Owners: 1996

Type of Ownership:

	VOLUNTARY,NON-PROFIT	xx	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		xx	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Ater **Telephone Number:** (309)823-7135

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Craig L. Ater

(Title) Senior V.P. & CFO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	178	Skilled (SNF)	178	64,970	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	178	TOTALS	178	64,970	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	32,686	14,425	12,384	59,495	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	32,686	14,425	12,384	59,495	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.57%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [xx]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [xx]

I. On what date did you start providing long term care at this location?
Date started 1996

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [xx]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified _____ and days of care provided 12,384

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [xx] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Heritage Manor-Springfield # 0041699 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	382,760	23,391		406,151		406,151	7,857	414,008			1
2	Food Purchase		290,936		290,936		290,936		290,936			2
3	Housekeeping	184,918	53,558		238,476		238,476	8	238,484			3
4	Laundry	137,571	16,404		153,975		153,975		153,975			4
5	Heat and Other Utilities			200,266	200,266		200,266	2,480	202,746			5
6	Maintenance	164,225	68,690	47,068	279,983		279,983	20,780	300,763			6
7	Other (specify):*											7
8	**TOTAL General Services**	869,474	452,979	247,334	1,569,787		1,569,787	31,125	1,600,912			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	3,130,354	240,660	10,233	3,381,247		3,381,247		3,381,247			10
10a	Therapy		803,719	663,348	1,467,067	(1,019,653)	447,414	160,688	608,102			10a
11	Activities	102,873	7,132		110,005		110,005		110,005			11
12	Social Services	111,703			111,703		111,703		111,703			12
13	CNA Training							2,792	2,792			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,344,930	1,051,511	691,581	5,088,022	(1,019,653)	4,068,369	163,480	4,231,849			16
	C. General Administration											
17	Administrative	66,923			66,923		66,923	120,457	187,380			17
18	Directors Fees							8,942	8,942			18
19	Professional Services			390,156	390,156		390,156	(365,310)	24,846			19
20	Dues, Fees, Subscriptions & Promotions			128,789	128,789	(96,360)	32,429	(6,061)	26,368			20
21	Clerical & General Office Expenses	327,608	34,736	30,007	392,351		392,351	248,636	640,987			21
22	Employee Benefits & Payroll Taxes			1,026,863	1,026,863		1,026,863	64,714	1,091,577			22
23	Inservice Training & Education			2,037	2,037		2,037	(38)	1,999			23
24	Travel and Seminar			9,553	9,553		9,553	(7,554)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			135,551	135,551		135,551	3,173	138,724			26
27	Other (specify):*			102,311	102,311		102,311	(100,495)	1,816			27
28	**TOTAL General Administration**	394,531	34,736	1,825,267	2,254,534	(96,360)	2,158,174	(33,536)	2,124,638			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,608,935	1,539,226	2,764,182	8,912,343	(1,116,013)	7,796,330	161,069	7,957,399			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heritage Manor-Springfield #0041699 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			274,404	274,404		274,404	21,086	295,490			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			164,560	164,560		164,560	30,440	195,000			32
33	Real Estate Taxes			122,304	122,304		122,304		122,304			33
34	Rent-Facility & Grounds							10,841	10,841			34
35	Rent-Equipment & Vehicles			9,604	9,604		9,604	2,732	12,336			35
36	Other (specify):*											36
37	**TOTAL Ownership**			570,872	570,872		570,872	65,099	635,971			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					1,019,653	1,019,653		1,019,653			39
40	Barber and Beauty Shops			16,944	16,944		16,944		16,944			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					96,360	96,360		96,360			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			16,944	16,944	1,116,013	1,132,957		1,132,957			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,608,935	1,539,226	3,351,998	9,500,159		9,500,159	226,168	9,726,327			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space	(50)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(6,270)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(854)	20		17
18	Fines and Penalties				18
19	Entertainment	(24,128)	24		19
20	Contributions	(295)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(19,758)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(100,200)	27		24
25	Fund Raising, Advertising and Promotional	(12,768)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,133)	23		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (166,456)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	392,624		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 392,624		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 226,168		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Heritage Manor-Springfield

ID# 0041699

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5		0	35	5
6		(50)	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(854)	20	17
18				18
19			24	19
20		(295)	27	20
21				21
22		(19,758)	19	22
23				23
24		(100,200)	27	24
25		(12,768)	20	25
26				26
27				27
28				28
29		(2,133)	23	29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(136,058)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Heritage Manor-Springfield **#** 0041699 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	7,857	0	0	0	0	0	0	0	0	7,857	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	8	0	0	0	0	0	0	0	0	8	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,480	0	0	0	0	0	0	0	0	2,480	5
6	Maintenance	0	0	20,780	0	0	0	0	0	0	0	0	20,780	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	31,125	0	0	0	0	0	0	0	0	31,125	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	160,688	0	0	0	0	0	0	0	0	0	160,688	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	2,792	0	0	0	0	0	0	0	0	2,792	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	160,688	2,792	0	0	0	0	0	0	0	0	163,480	16
	C. General Administration													
17	Administrative	0	0	120,457	0	0	0	0	0	0	0	0	120,457	17
18	Directors Fees	0	0	8,942	0	0	0	0	0	0	0	0	8,942	18
19	Professional Services	(19,758)	(370,398)	24,846	0	0	0	0	0	0	0	0	(365,310)	19
20	Fees, Subscriptions & Promotions	(13,622)	0	7,561	0	0	0	0	0	0	0	0	(6,061)	20
21	Clerical & General Office Expenses	0	0	248,636	0	0	0	0	0	0	0	0	248,636	21
22	Employee Benefits & Payroll Taxes	0	0	64,714	0	0	0	0	0	0	0	0	64,714	22
23	Inservice Training & Education	(2,133)	0	2,095	0	0	0	0	0	0	0	0	(38)	23
24	Travel and Seminar	(24,128)	0	16,574	0	0	0	0	0	0	0	0	(7,554)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,173	0	0	0	0	0	0	0	0	3,173	26
27	Other (specify):*	(100,495)	0	0	0	0	0	0	0	0	0	0	(100,495)	27
28	**TOTAL General Administration**	(160,136)	(370,398)	496,998	0	0	0	0	0	0	0	0	(33,536)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(160,136)	(209,710)	530,915	0	0	0	0	0	0	0	0	161,069	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Heritage Manor-Springfield** **#** **0041699** **Report Period Beginning:** **01/01/05** **Ending:** **12/31/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	21,086	0	0	0	0	0	0	0	21,086	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,270)	0	0	36,710	0	0	0	0	0	0	0	30,440	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(50)	0	0	10,891	0	0	0	0	0	0	0	10,841	34
35	Rent-Equipment & Vehicles	0	0	0	2,732	0	0	0	0	0	0	0	2,732	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(6,320)	0	0	71,419	0	0	0	0	0	0	0	65,099	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(166,456)	(209,710)	530,915	71,419	0	0	0	0	0	0	0	226,168	45

Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [xx] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	10a	Adjustment for Related Organization						2
3	V								3
4	V	19	Adjustment for Related Organization	370,398	Heritage Enterprises, Inc.	100.00%		(370,398)	4
5	V								5
6	V	10a	Adjustment for Related Organization	799,046	GreenTree Pharmacy	100.00%	959,734	160,688	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,169,444			$ 959,734	$ * (209,710)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Heritage Enterprises, Inc.	100.00%	$ 7,857	$ 7,857	15
16	V	2	Food Purchase				0		16
17	V	3	Housekeeping				8	8	17
18	V	4	Laundry				0		18
19	V	5	Heat & Other Utilities				2,480	2,480	19
20	V	6	Maintenance				20,780	20,780	20
21	V	7	Other				0		21
22	V	9	Medical Director				0		22
23	V	10	Nursing & Medical Records				0		23
24	V	11	Activities				0		24
25	V	12	Social Service				0		25
26	V	13	Nurse Aide Training				2,792	2,792	26
27	V	14	Program Transportation				0		27
28	V	15	Other				0		28
29	V	17	Administrative				120,457	120,457	29
30	V	18	Directors Fees				8,942	8,942	30
31	V	19	Professional Services				24,846	24,846	31
32	V	20	Fees, Subscription, Promotions				7,561	7,561	32
33	V	21	Clerical & General Office Expenses				248,636	248,636	33
34	V	22	Employee Benefits & Payroll Taxes				64,714	64,714	34
35	V	23	Inservice Training & Education				2,095	2,095	35
36	V	24	Travel and Seminar				16,574	16,574	36
37	V	25	Other Admin. Staff Transportation				0		37
38	V	26	Insurance-Prop.Liab.Malpract				3,173	3,173	38
39	Total			$			$ 530,915	$ * 530,915	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	$	Heritage Enterprises, Inc.	100.00%	$	$ 0	15
16	V	30	Depreciation					21,086	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					36,710	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					10,891	20
21	V	35	Rent-Equipment & Vehicles					2,732	21
22	V	36	Other					0	22
23	V	38	Medically Nec Transportation					0	23
24	V	39	Ancillary Service Centers					0	24
25	V	40	Barber and Beauty Shops					0	25
26	V	41	Coffee and Gift Shops					0	26
27	V	42	Other					0	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ * 71,419	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Heritage Enterprises			50.00					$ 8,942	Ln 18	1
2	Memorial Health Ventures			50.00							2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 8,942		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [xx] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Heritage Enterprises
Street Address: 115 W. Jefferson
City / State / Zip Code: Bloomington,Il
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,612	25	$ 115,289	$ 115,276	178	$ 7,857	1
2	2	Food Purchase	Beds	2,612	25	7	0	178	0	2
3	3	Housekeeping	Beds	2,612	25	124	0	178	8	3
4	4	Laundry	Beds	2,612	25	0	0	178	0	4
5	5	Heat & Other Utilities	Beds	2,612	25	36,387	0	178	2,480	5
6	6	Maintenance	Beds	2,612	25	304,933	79,110	178	20,780	6
7	7	Other	Beds	2,612	25	0	0	178	0	7
8	9	Medical Director	Beds	2,612	25	0	0	178	0	8
9	10	Nursing & Medical Records	Beds	2,612	25	0	0	178	0	9
10	11	Activities	Beds	2,612	25	0	0	178	0	10
11	12	Social Service	Beds	2,612	25	0	0	178	0	11
12	13	Nurse Aide Training	Beds	2,612	25	40,976	40,976	178	2,792	12
13	14	Program Transportation	Beds	2,612	25	0	0	178	0	13
14	15	Other	Beds	2,612	25	0	0	178	0	14
15	17	Administrative	Beds	2,612	25	1,767,611	1,767,611	178	120,457	15
16	18	Directors Fees	Beds	2,612	25	131,223	0	178	8,942	16
17	19	Professional Services	Beds	2,612	25	364,592	0	178	24,846	17
18	20	Fees, Subscription, Promotions	Beds	2,612	25	110,958	0	178	7,561	18
19	21	Clerical & General Office Expens	Beds	2,612	25	3,648,522	3,309,912	178	248,636	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,612	25	949,625	0	178	64,714	20
21	23	Inservice Training & Education	Beds	2,612	25	30,747	0	178	2,095	21
22	24	Travel and Seminar	Beds	2,612	25	243,204	0	178	16,574	22
23	25	Other Admin. Staff Transportatio	Beds	2,612	25	0	0	178	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,612	25	46,560	0	178	3,173	24
25	TOTALS					$ 7,790,758	$ 5,312,885		$ 530,915	25

Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,612	25	$	$	178	$	1
2	30	Depreciation	Beds	2,612	25	309,426		178	21,086	2
3	31	Amortization of Pre-Op & Org	Beds	2,612	25			178		3
4	32	Interest	Beds	2,612	25	538,695		178	36,710	4
5	33	Real Estate Taxes	Beds	2,612	25			178		5
6	34	Rent-Facility & Grounds	Beds	2,612	25	159,809		178	10,891	6
7	35	Rent-Equipment & Vehicles	Beds	2,612	25	40,093		178	2,732	7
8	36	Other	Beds	2,612	25			178		8
9	38	Medically Nec Transportation	Beds	2,612	25			178		9
10	39	Ancillary Service Centers	Beds	2,612	25			178		10
11	40	Barber and Beauty Shops	Beds	2,612	25			178		11
12	41	Coffee and Gift Shops	Beds	2,612	25			178		12
13	42	Other	Beds	2,612	25			178		13
14								178		14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,048,023	$		$ 71,419	25

Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	Bank of Springfield		xx	Mortgage	4640 plus Int	01/15/99	$	$ 2,463,022	01/15/06	variable	$ 158,024	1
2	Bank of Springfield		xx	Mortgage							515	2
3												3
4												4
5												5
	Working Capital											
6	Bank of Springfield		xx	Working Capital				660,000			6,021	6
7	Bank of Springfield		xx	Working Capital								7
8												8
9	TOTAL Facility Related						$	$ 3,123,022			$ 164,560	9
	B. Non-Facility Related*											
10	Interest Income										(6,270)	10
11												11
12	Allocated Interest										36,710	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 30,440	14
15	TOTALS (line 9+line14)						$	$ 3,123,022			$ 195,000	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Heritage Manor-Springfield **#** 0041699 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$ 116,557	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 116,518	2
3. Under or (over) accrual (line 2 minus line 1).	$ (39)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 122,343	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 122,304	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	88,571	8
2001	111,306	9
2002	104,972	10
2003	110,337	11
2004	111,275	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor-Springfield COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0041699

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-28-277-027	Heritage Manor-Springfield	$ 116,518.00	$ 116,518.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 116,518.00	$ 116,518.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,805 B. General Construction Type: Exterior brick/wood Frame wood Number of Stories 1

C. Does the Operating Entity? [xx] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [xx] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [xx] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$ 630,000	1
2					2
3	TOTALS			$ 630,000	3

Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	178				$ 1,900,000	$		$	$	$	4
5					1,648,258						5
6											6
7											7
8											8
	Improvement Type**										
9	1985 Improvements			1985	26,076						9
10	1986 Improvements			1986	216,545						10
11	1987 Improvements			1987	593,121						11
12	1988 Improvements			1988	29,321						12
13	1989 Improvements			1989	1,095						13
14	1990 Improvements			1990	939						14
15	1991 Improvements			1991	32,022						15
16	1992 Improvements			1992	32,593						16
17	1993 Improvements			1993	105,986						17
18	1994 Improvements			1994	59,542						18
19	1995 Improvements			1995	36,126						19
20	Laundry Chute			1996	4,926						20
21	Door Alarm			1996	8,533						21
22	Garbage Disposal			1996	1,113						22
23	Elevator			1996	11,439						23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	C/O Allocation							21,086	21,086		34
35	Book Depreciation					223,753		223,753		2,338,409	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Vent Shaft	1997	$ 6,267	$		$	$	$	37
38	Fire Dampers	1997	510						38
39	Computer Cabling	1997	14,518						39
40	Rehab Therapy Room	1997	7,391						40
41	Air Conditioner--Chiller	1997	47,954						41
42	Remodel First Floor	1997	27,570						42
43									43
44	Landscape	1998	2,410						44
45	Vent Work	1998	7,018						45
46	Asphalt Ramp	1998	850						46
47	Room Remodel	1998	1,142						47
48									48
49	Code Alert	1999	7,829						49
50	Wall Paper	1999	704						50
51	Remodel Office Interior	1999	1,248						51
52	Elevator Repair	1999	2,697						52
53	Carpet	1999	1,097						53
54									54
55	Shed Yardmate	2000	522						55
56	A/C Rooftop Unit	2000	2,937						56
57	Sewerline Repair	2000	1,482						57
58									58
59	Facility Renovation--Materials	2001	745,911						59
60	Facility Renovation--Labor	2001	1,463						60
61	Facility Renovation--Interior Design	2001	69,313						61
62	Fire Alarm System	2001	8,718						62
63	Sewer Line Repair	2001	1,787						63
64									64
65	Facility renovations: Paint , wallpaper, fixtures , floor coverings for all resident								65
66	rooms including hallways and common areas								66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,668,973	$ 223,753		$ 244,839	$ 21,086	$ 2,338,409	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,668,973	$ 223,753		$ 244,839	$ 21,086	$ 2,338,409	1
2	Landscape Design	2002	500						2
3	Freezer Compressor	2002	3,834						3
4	Smoke Detectors	2002	2,560						4
5	Facility Renovation--Materials	2002	186,172						5
6	Facility Renovation--Labor	2002	3,561						6
7	Facility Renovation--Interior Design	2002	15,497						7
8	Phone System	2002	2,064						8
9									9
10	Door Security	2003	2,597						10
11	Generator	2003	20,145						11
12	Door Replacement	2003	1,216						12
13	Generator Replacement	2003	9,244						13
14	Elevator Repair	2003	12,378						14
15	Shower Room Remodel	2003	17,153						15
16	Hallway carpet	2003	3,889						16
17	Boiler Door	2003	854						17
18									18
19	Shower Room Remodel	2004	37,959						19
20	Elevator Repair	2004	96,846						20
21	Condensing Unit	2004	7,204						21
22	Privacy Door	2004	1,226						22
23									23
24	Controller board	2005	2,460						24
25	Wall Railing	2005	2,837						25
26	A/C Protection	2005	1,318						26
27	Compressor	2005	10,800						27
28	Chiller	2005	2,305						28
29	Rooftop Compressor	2005	4,676						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,118,268	$ 223,753		$ 244,839	$ 21,086	$ 2,338,409	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,244,825	$ 50,651	$ 50,651	$		$ 1,112,199	71
72	Current Year Purchases	18,538						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,263,363	$ 50,651	$ 50,651	$		$ 1,112,199	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,011,631	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 274,404	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 295,490	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 21,086	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,450,608	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 12,336 Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - ☐ YES
   - ☐ NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 222,868	$		$ 222,868	1
2	Licensed Speech and Language Development Therapist		hrs			72,300			72,300	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			308,265	4,670		312,935	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				959,738		959,738	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					59,915			59,915	13
14	TOTAL			$		$ 663,348	$ 964,408		$ 1,627,756	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Heritage Manor-Springfield **#** 0041699 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 153,662	$	1
2	Cash-Patient Deposits	26,925		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,850,200		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	54,325		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(5,410)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,079,702	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	630,000		13
14	Buildings, at Historical Cost	6,118,268		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,263,362		16
17	Accumulated Depreciation (book methods)	(3,450,608)		17
18	Deferred Charges	1,638,626		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	686		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,200,334	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,280,036	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 218,988	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,925		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	122,343		32
33	Accrued Interest Payable	14,994		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 383,250	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,123,022		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,123,022	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,506,272	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,773,764	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,280,036	$	48

***(See instructions.)**

Facility Name & ID Number Heritage Manor-Springfield **#** 0041699 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,468,318	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,468,318	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	305,446	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 305,446	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,773,764	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,794,471	1
2	Discounts and Allowances for all Levels	(3,260,431)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,534,040	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,850,809	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,850,809	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	4,075	12
13	Barber and Beauty Care	22,063	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	50	16
17	Sale of Drugs	1,393,519	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	44	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,419,751	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,270	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,270	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,810,870	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,569,787	31
32	Health Care	5,088,022	32
33	General Administration	2,254,534	33
	B. Capital Expense		
34	Ownership	570,872	34
	C. Ancillary Expense		
35	Special Cost Centers	16,944	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37		5,265	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,505,424	40
41	**Income before Income Taxes (line 30 minus line 40)****	305,446	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 305,446	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,976	2,160	$ 58,475	$ 27.07	1
2	Assistant Director of Nursing	2,015	2,283	53,196	23.30	2
3	Registered Nurses	29,106	31,526	669,137	21.22	3
4	Licensed Practical Nurses	49,726	53,458	922,790	17.26	4
5	CNAs & Orderlies	115,703	123,302	1,376,899	11.17	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,636	3,991	49,857	12.49	8
9	Activity Director					9
10	Activity Assistants	11,351	12,636	102,873	8.14	10
11	Social Service Workers	6,363	7,051	111,703	15.84	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	41,929	44,441	382,760	8.61	15
16	Dishwashers					16
17	Maintenance Workers	16,361	17,665	164,225	9.30	17
18	Housekeepers	20,608	22,606	184,918	8.18	18
19	Laundry	12,080	12,931	137,571	10.64	19
20	Administrator	1,900	2,080	66,923	32.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,352	21,101	327,608	15.53	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	329,106	357,231	$ 4,608,935 *	$ 12.90	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		18,000		36
37	Medical Records Consultant		0		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,134		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		0		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 22,134		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ruth Kopec	admin		$ 66,923
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 66,923

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Enterprises	Mgt Fees	$ 370,398
		0
		0
		0
		19,758
		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 390,156

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 235,778
Unemployment Compensation Insurance	63,486
FICA Taxes	352,584
Employee Health Insurance	336,294
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	0
Employee Benefits -	38,721
Employee Benefits - central office	64,714
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,091,577

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	2,565
Health Care Worker Background Check	
(Indicate # of checks performed)	1,570
Central Office Allocation	7,561
Promotional Advertising	8,472
Public Relations	4,296
Dues and Subscriptions	12,411
License and Fees	1,125
Less: Public Relations Expense	(4,296)
Non-allowable advertising	(854)
Yellow page advertising	(8,472)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,368

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	3,304
	0
Seminar Expense	6,249
	(24,128)
	16,574
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Heritage Manor-Springfield **#** 0041699 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **xx** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **96,360**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **9,385**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Sulaski & Webb** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not available**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

BASIC CHARGE-PRIVATE & VA	-8,819,667	
PRIVATE ASSESSMENT TAX INCOME		
BASIC CHARGE-IPA	0	
BASIC CHARGE-MEDICARE	0	
DAY CARE/HOME CARE		
LIGHT NURSING CARE	-205,744	
MEDIUM NURSING CARE		
HEAVY NURSING CARE		
SKILLED NURSING CARE		
NURSING SUPPLIES-PRIVATE	-681,673	
NURSING SUPPLIES-IPA		
NURSING SUPPLIES MED PT A		
NURSING SUPPLIES MED PT B		
DRUGS	-1,393,519	
DRUGS-OTHER		
PT-PRIVATE	-1,850,809	
PT-IPA		
PT-MEDICARE PART A		
PT-MEDICARE PART B		
PUBLIC AID ASSESSMENT INC		
LABORATORY INCOME		
SPEECH/OT-PRIVATE		
SPEECH/OT-IPA		
SPEECH/OT-MED PART A		
SPEECH/OT MED PART B		
IPA DISCOUNTS	3,260,431	
MEDICAID PART B DISCOUNT		
MEDICARE DISCOUNTS		
ASSESSMENT TAX EXPENSE		
RENT INCOME	-50	
BEAUTY SHOP	-22,063	
ACTIVITY FUND INCOME	-1,496	
VENDING INCOME/EXPENSE	-2,579	
MANAGEMENT FEES		
EQUIPMENT RENTAL	-87,387	
RESIDENT TRANSPORTATION	553	
MISC INCOME	-597	
GENERAL & ADMINIST WAGES	309,551	327,608
ADMINISTRATOR WAGES	66,923	66,923
VACATION & SICK - G&A	18,057	
EMPLOYEE BENEFITS	20,364	1,026,863
EMPLOYEE HEPETITIS VACCINI	0	
EMPLOYEE SCHOLORSHIP WAG	13,963	
EMPLOYEE SCHOLORSHIP COS	4,394	
DIRECTORS FEES		
OFFICE SUPPLIES	34,736	34,736
TELEPHONE	30,007	30,007
TRAINING & EMPLOYEE DEVL	2,037	2,037
GENERAL TRAVEL	3,304	9,553
MEAL EXPENSE FOR TRAVEL	0	
EDUCATION & SEMINAR	6,249	
HELP WANTED ADVERTISING	2,565	128,789
PROMOTIONAL ADVERTISING	8,472	
PUBLIC RELATIONS	4,296	
LICENSES & FEES	99,475	
DUES & SUBSCRIPTIONS	12,411	
CONTRIBUTIONS	295	
PROFESSIONAL FEES	19,758	390,156
MEDICAL DIRECTOR	18,000	18,000
UTILIZATION REVIEW	0	
OTHER PHYSICIAN FEES	0	
MEDICAL RECORDS CONSULT	0	
PHARMACIST FEES	4,134	
SOC SERV/ACT CONSULT	0	0
TV RENTAL	-1,630	
INCOME TAXES		102,311
BACKGROUND CHECKS	1,570	
PAYROLL TAXES	409,123	
PAYROLL TAXES ADMINIST	6,947	
GROUP INSURANCE	336,294	
LIABILITY INSURANCE	135,551	135,551
INSURANCE-OWNERS		
WORKMENS COMP INSURANCE	235,778	
CENTRAL OFFICE FEES	370,398	
BAD DEBTS	100,200	
LOST ITEMS-RESIDENTS	1,816	
MISCELLANEOUS	0	
REAL ESTATE TAXES	122,304	122,304
LEASED EQUIPMENT	11,234	9,604
MAINTENANCE SALARIES	156,726	164,225
MAINTENANCE SICK & VAC	7,499	
ELECTRIC	91,465	200,266
NATURAL GAS	87,682	
HEATING & DEISEL OIL		
WATER & SEWER	21,119	
TRASH COLLECTION	17,769	47,068
PROPERTY PLANT REPLACEMN	7,020	68,690
GENERAL REPAIR & MAINT	61,670	
MAINTENANCE CONTRACTS	29,299	
DIETARY WAGES	362,461	382,760
DIETARY SICK & VAC	20,299	
SALES TAX		
FOOD PURCHASES	300,321	290,936
SUPPLIES-DISHWASHING	5,237	23,391
DIETARY REPLACEMENT	3,459	
KITCHEN SUPPLIES-PAPER	14,695	
MEAL CREDIT	-9,385	
LAUNDRY WAGES	129,481	137,571
LAUNDRY SICK & VAC	8,090	
LAUNDRY REPLACEMENT	5,893	16,404
LAUNDRY REIMBURSEMENT		
LAUNDRY SUPPLIES	10,511	
HOUSEKEEPING WAGES	171,022	184,918
HOUSEKEEPING SICK & VAC	13,896	
HOUSEKEEPING SUPPLIES	17,645	53,558
HOUSEKEEPING SUPPLIES-PPR	35,913	
RN WAGES-MEDICARE		3,130,354
RN WAGES-NON MEDICARE	615,487	
DON WAGES	58,475	
ADON	53,196	
RN SICK & VACATION	53,650	
LPN WAGES-MEDICARE	0	
LPN WAGES-NON MEDICARE	857,940	
LPN WAGES OTHER		
LPN SICK & VACATION	64,850	
AIDE WAGES-MEDICARE		
AIDE WAGES-NON MEDICARE	1,264,288	
WARD CLERKS		
AIDE VACATION & SICK	112,611	
CONTRACT NURSES-RN	0	
CONTRACT NURSES-LPN	0	
CONTRACT NURSES-AIDES	0	
NURSE AIDE TRAINING WAGES	0	0
NURSE AID TRAINING EXP	0	0
NURSE AIDE TRAINING REIMB	0	
REHAB WAGES	47,793	
REHAB SICK & VAC	2,064	
NURSING DEPT EDUCATION		
NURSING SUPPLIES	214,838	240,660
NURSING SUPPLIES	23,605	
REPLACEMENT-NURSING	2,217	
NURSING OTHER	6,099	10,233
DRUG PURCHASES	513,097	803,719
DRUG PURCHASES-OTHER	285,952	
LABORATORY SERVICES	59,915	663,348
HOME HEALTH SALARY		
HOME HEALTH SICK & VAC		
HOME HEALTH EXPENSES		
ACTIVITES WAGES	96,933	102,873
ACTIVITIES SICK & VAC	5,940	
ACTIVITIES SUPPLIES	7,132	7,132
ACTIVITIES FEES	0	0
PT WAGES		
PT SICK & VACATION		
PT FEES	308,265	
PT SUPPLIES	4,670	
SOCIAL SERVICE WAGES	105,032	111,703
SOCIAL SERVICE SICK & VAC	6,671	
SOCIAL SERVICE EXPENSES	0	0
OT FEE	222,868	
SOCIAL THERAPIST FEE	0	0
SPEECH THERAPY FEE	72,300	
BEAUTICIAN WAGES		0
BEAUTICIAN SICK & VAC		
BEAUTICIAN FEES	16,944	16,944
BEAUTY SHOP SUPPLIES	0	0
VOLUNTEER COORDINATOR		
VOL COORD SICK & VAC		
VOL COORD SUPPLIES	0	
RENT		0
INTEREST EXPENSE	164,045	164,560
DEPRECIATION	274,404	274,404
LOAN FEE AMORTIZATION	515	
INTEREST INCOME	-6,270	
MISC NON-OPERATING INCOMI	0	
INCOME TAXES	5,265	
	9,499,154	9,500,159
		1,005
	-305,446	
	(NET INCOME)	
	0	